Inspecting Informing Improving

Healthcare Commission

Improving services for children in hospital

Report of the follow-up to the 2005/06 review

Follow-up review

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Summary

The aim of our programme of service reviews is to help trusts to improve their services. Our review of services for children in hospital was carried out in 2005/06, and the national report was published in February 2007. The review highlighted a number of areas that needed to improve and we made recommendations to help this happen. This follow-up enables us to measure what improvements have been made in these areas in the intervening period.

The follow-up also continues to support improvement by providing trusts with individual performance reports based on the latest national benchmarking data and through targeted intervention and workshops, arranged by our regional staff, for the trusts with the greatest need to improve.

Findings from both the original review and the follow-up provide information for primary care trusts (PCTs) that are responsible for commissioning services, strategic health authorities (SHAs) and Monitor (the body responsible for managing the performance of foundation trusts), to help them consider the future development and planning of childrens' services networks, and the resources needed for training and developing skills.

The original review in 2005/06 assessed 157 NHS trusts. The main findings were:

- 25% of trusts received an overall score of "excellent" or "good", and were making good progress in improving services for children.
- The majority (70%) of trusts were scored as "fair", and were largely satisfactory, although improvements were necessary to provide better, child-friendly services.
- 5% of trusts received a score of "weak", and were not meeting a significant number of key aspects of the *National Service Framework for Children, Young People and Maternity Services*, that apply to hospital services.

The review also found that across all trusts assessed, inpatient services were providing the best child-focused care, with 71% scoring "good" or "excellent" for these services. In contrast, 28% of trusts scored "weak" in emergency care and in day case settings, and 46% scored "weak" in outpatient settings. The follow-up to the review therefore focused on these settings.

Providing training for staff and maintaining their skills were the main issues that needed improvement. These therefore formed the basis of the follow-up to the review, which focused on the following four key issues:

1. Child protection training for nurses, consultant surgeons and consultant anaesthetists in emergency care and day case care.
2. Managing pain and administration of analgesia by nurses in emergency care and day case care.
3. Training in life support for nurses, consultant surgeons and consultant anaesthetists.
4. Maintaining the skills of appropriately experienced staff in outpatient and surgical settings.

In the follow-up review, we used 19 indicators from the original review to assess the performance of each trust against these four key issues. The data produced from this assessment placed trusts in one of four categories that describe the level of change for each indicator, based on consistent data and thresholds from both the original and follow-up reviews. The categories are:

- **Consistently high performing:** the trust's performance in both the 2005/06 review and in the 2008/09 follow-up review was above the threshold.
- **Improved:** the trust's performance in the 2005/06 review was below the set threshold and was above the threshold in the 2008/09 follow-up review.
- **Deteriorated:** the trust's performance in the 2005/06 review was above the set threshold, and was below the threshold in the 2008/09 follow-up review.
- **Consistently low performing:** the trust's performance in both the 2005/06 and in the 2008/09 follow-up reviews was below the threshold.

The indicators and thresholds are based on good practice guidelines and may raise questions about the safety and configuration of services that trusts should investigate. However, they do not in themselves provide sufficient information to say whether a particular service is unsafe.

Overall, the follow-up shows a mixed picture of improvement in some areas and very little improvement in others. However, the baseline for improvement is low in many cases and this suggests that there is still a long way to go.

The results for each theme were:

1. **Child protection:** overall, 71% of the trusts' scores across the indicators used in this theme were categorised as "improved" (39%) or "consistently high performing" (32%). It is concerning that 29% of trusts' scores still do not meet this basic minimum level of child protection training for key staff who work with children.
2. **Managing pain:** this covered nurses in emergency care and day case settings and showed overall that only 59% of trusts' scores across the indicators had the equivalent of one nurse per shift who was trained to assess and treat pain in children.
3. **Life support:** overall, 74% of trusts' scores did not meet the guidelines for this important training. This figure includes 11% of trusts that had "deteriorated" since the original review. We are concerned that many trusts do not have an adequate number of trained staff for children's services, or, in some cases, lack records of training for both nursing and medical staff with the appropriate and updated training in life support.
4. **Maintaining the skills of staff in surgery and outpatient departments:** again, we found that very poor attention had been given to the recommendation from the original review that surgeons and anaesthetists working with children need to undertake sufficient work to maintain their skills. Trusts' scores for the relevant indicators show an overall 63% categorised as "consistently low performing" and a further 9% as "deteriorated". We are concerned that some trusts may still offer surgical procedures to younger children

carried out by staff that have not been able to meet the good practice guidance of carrying out a sufficient level of work to properly maintain their skills. However, we do recognise that a balance needs to struck, particularly in rural areas, between providing care locally and the risk of not achieving sufficient numbers of procedures to allow staff to properly maintain their skills. We are also concerned that the provision of a registered children's nurse in each outpatient department when children are present remains poor.

Conclusions

While we recognise that trusts have made some improvements in the two key areas of child protection and managing pain since our original review, some trusts are still not systematically training staff to ensure that all services can meet children's needs appropriately.

We recommend that the frequency of child protection training should be increased to once a year, rather than the current recommended minimum frequency of once every three years, as many trusts are already achieving this level.

It is of great concern that the findings from the follow-up review show a consistently low level in the uptake of training in paediatric life support among key staff, while a high proportion of surgeons and anaesthetists carrying out procedures on children still need to have more work experience with children to properly maintain their specific skills. Trusts that need to improve should look to those that are already achieving high levels of performance as beacons of good practice.

Trusts must consider and address these concerns urgently with their commissioning PCTs to ensure that they are providing high quality care for children that is both safe and effective. In particular, some trusts also need to improve how they record the training and skills levels of key groups of staff to ensure that the specific medical, surgical and nursing skills needed for child-focused care are maintained.

Introduction

Purpose of this report

This report sets out the overall results of our follow-up of the review of services for children in hospital. The report explores to what extent services have improved since the original review in 2005/06. It is aimed primarily at the boards of trusts, clinical staff and managers in the NHS. Separate reports for each individual trust are available on our website www.healthcarecommission.org.uk.

This report should be read alongside the individual reports for each trust and the report of the original review, *Improving Services for Children in Hospital*, which sets out the context for the follow-up work and provides detailed recommendations for improvement in services for children in hospital.[1]

What is a follow-up review?

The Healthcare Commission aims to promote ongoing improvements in healthcare. We provide assurance to patients and the public that improvements are taking place by following up our reviews of services that we have carried out previously. Service reviews are detailed investigations of particular services or aspects of healthcare that include an assessment of the performance of each NHS trust and other NHS organisations involved. We ask NHS trusts that have participated in a service review to make use of their results and implement the published recommendations to improve their services where necessary.

Follow-up reviews specifically aim to:

- Monitor change in a trust's performance, focusing on the areas most in need of improvement.
- Provide a national summary of progress as well as individual reports on the performance of trusts.
- Help trusts whose services have failed to improve or have deteriorated to create an action plan to improve.

Our regional teams are already carrying out targeted work with selected trusts to help them develop and implement their action plans.

What were the findings of the original review?

The review of services for children in 157 acute hospital trusts, carried out in 2005/06, is the first service review to be followed up in this way. The review was based on standard 6 of the *National Service Framework for Children, Young People and Maternity Services*[2]. The data and scores for performance at trust level were published in August 2006.

The national report published in February 2007 explored five key principles:

- Children have access to child-specific services.
- Children have access to care local to their homes.

- Services are staffed by appropriate levels of trained staff.
- Staff have child-specific training.
- Staff have the opportunity to maintain their skills.

After providing trusts with their results, we carried out targeted work with the 10% of weakest-performing trusts in the review to develop an action plan, as well as with the 18% of trusts that did not have sufficient cover to provide life support in serious emergencies.

The review found that hospitals were mostly child-friendly and provided local services where appropriate, but many trusts needed to improve training in:

- Child protection.
- Pain management.
- Communication and play.

We identified some risks in the quality of medical and surgical care in a minority of trusts, which we addressed with them immediately.

Overall, 25% of trusts received a score of "excellent" or "good", and were making good progress in improving their services for children. The majority (70%) were scored as "fair", and were largely satisfactory, although improvements were necessary to provide better, child-friendly services. Five per cent of trusts received a score of "weak", indicating that they were not yet meeting a significant number of key elements from the National Service Framework. We found, at the time, that inpatient services were generally good (70% of trusts scored "good" or "excellent" for these services), but we had serious concerns over services for children in emergency care and in day case settings, with 28% of trusts scoring "weak" in each case. Moreover, 46% of trusts scored "weak" in relation to outpatient services, indicating that many trusts were not systematically training staff or designing services to specifically meet the needs of children.

The key recommendations from the review were that the boards of hospital trusts had to ensure themselves and their local population that they were providing services for children in hospital that:

- Were of high quality and clinically safe, with suitable levels of staff that were appropriately trained and that could maintain their skills in surgery, life support and pain management.
- Met the requirements for effective safeguarding of children.
- Addressed the broader needs of children for communication and play.
- Were delivered in child-focused environments.

The aim of this follow-up review is to check that improvements in these key areas have taken place and that the recommendations are being implemented.

Measuring the performance of trusts

Selection of indicators for follow-up

The national report of the original review identified 11 indicators that needed the most improvement as the basis of a future follow-up. The rationale for selecting these indicators is outlined in appendix A. This approach, and the chosen set of indicators, was endorsed by a professional advisory group that was formed to support the original review.

The advisory group was reformed in September 2008 to review the indicators to be used in the follow-up, confirm their continued relevance and advise on how to conduct the follow-up review.

The selected indicators focus in particular on the training and skills that are required to deliver a high quality service that meets the needs of children in hospital, grouped into four main themes shown on the opposite page.

We selected 19 individual indicators across these four themes. They are components of the composite indicators from the original review that have now been separated into individual indicators in order to provide greater clarity and more detailed feedback for trusts to target improvements. The indicators are listed in appendix B, and details of the guidance on which these indicators are based are listed in appendix D.

The original review provided performance scores for a wide range of trust and site-based indicators, which were combined to form an overall score for a trust's performance. This follow-up looks at performance against each of the 19 selected indicators. These form only a relatively small part of all the indicators used in the original review, so we cannot reproduce an overall score for trusts.

We used a two-stage approach to measure change in trusts' performance between the time of the original review and the follow-up review:

- Measure the trusts' performance in the original review and the follow-up review.
- Assess whether the trust has improved, deteriorated or stayed the same against the performance threshold set in the original review.

The thresholds were reviewed to ensure that they are in line with current practice and those used are set out against each indicator in appendix B. If they have been changed (and this particularly applies to the requirements for training in safeguarding) to enable us to compare them, the new thresholds have been applied to both the original and follow-up review data.

Categories of performance

For each indicator we describe change in four categories:

- **Consistently high performing:** the trust's performance in both the 2005/06 review and in the 2008/09 follow-up review was above the threshold.
- **Improved:** the trust's performance in the 2005/06 review was below the set threshold and was above the threshold in the 2008/09 follow-up review.
- **Deteriorated:** the trust's performance in the 2005/06 review was above the set threshold, and was below the threshold in the 2008/09 follow-up review.

Theme 1: Child protection
Child protection training for nurses, consultant surgeons and consultant anaesthetists in settings such as emergency care, day case care, and surgery. The courses include:

- Child protection training at level 1 or higher at least every three years for all staff.
- Child protection training at level 2 or higher at least every three years for at least one nurse per shift.

Theme 2: Managing pain
Pain management training for nurses in settings such as emergency care and day case care. The training courses include:

- Formal training for the use of paediatric pain assessment tools.
- Administration of analgesia via PGDs training.*

Theme 3: Life support
Life support training for nurses, consultant surgeons and consultant anaesthetists in settings such as emergency care, day case care and surgery. The training courses include:

- Paediatric life support (PLS) or basic paediatric resuscitation training.
- Advanced paediatric life support (APLS) or equivalent training courses such as European paediatric life support (EPLS) or paediatric advanced life support (PALS) training.

Theme 4: Maintaining the skills of staff in surgery and outpatient departments
Ensuring that there are suitable levels of appropriately experienced and trained staff in outpatient and surgical settings:

- Teams of consultant surgeons have carried out an adequate level of work on children to maintain their skills.
- Consultant anaesthetists have carried out an adequate level of work on children to maintain their skills.
- A registered children's nurse is working in each outpatient department when it is being used by children.

* Patient Group Directions (PGDs) are documents that make it legal for medicines to be given to specific groups of patients without individual prescriptions having to be written for each patient. They can also be used to empower staff other than doctors (for example paramedics and nurses) to legally give the medicine in question.

- **Consistently low performing:** the trust's performance in both the 2005/06 and in the 2008/09 follow-up reviews was below the threshold.

The indicators and thresholds are based on good practice guidelines and may raise questions about the safety and configuration of services that trusts should investigate. However, they do not in themselves provide sufficient information to say whether a particular service is unsafe.

Missing data

Trusts that were unable to submit data, or that failed to submit it within the timeframe specified, were treated as performing below the threshold.

In a few instances 'No category' or 'Not applicable' was given to a trust for a specific indicator. This happened when there was no available matching data between the original review and the follow-up review, or where trusts had notified us in the data gathering process that they did not provide a particular service (for example, emergency care services) and, therefore, these trusts could not provide data for the indicator.

Data sources

For the original review, data was collected directly from trusts during 2005/06 covering the period 1 October 2004 to 30 September 2005. The follow-up data was collected during the winter of 2007/08 through the Child Health Mapping project at Durham University* that is supported by the Department of Health. It covered the period 1 October 2006 to 30 September 2007, with the headcount data being based on 30 November 2007. A pilot data collection exercise was also carried out in 2006/07 by the mapping team to test the process, and an individual report was sent to each participating trust in December 2007.

This follow-up review involved 154 trusts.** In the original review, we used a ruling that excluded trusts that had a low proportion of work with children (fewer than 4% of the workload including finished consultant episodes (FCE) for day cases and inpatients), and we applied the same ruling to this follow-up review.

* Child health and maternity services and Child and adolescent mental health services mapping are commissioned by the Department of Health in partnership with the Care Services Improvement Partnership. It is run by the Durham University Mapping Team and managed by the National Children's Mapping Lead.

** The restructure and re-organisation of the services of NHS trusts in October 2006 caused a number of trusts to merge to become new trusts. The majority of new trusts were created by bringing together services or a number of trusts into a single new trust. For these, we have added together the data from the old trusts from which the new trust was formed.

Summary of the national findings

This section provides a summary and discussion of the main results for each of the four themes under which the indicators are grouped. The percentages of trusts' scoring in each category for each indicator are given in appendix C. More details of the raw indicator values are given in the reports for each trust on our website.

Theme 1: Child protection

Training in child protection was identified as a major risk area for trusts in the original review. The report stated that trusts need to make sure that staff at all levels are aware of their corporate and individual responsibility to safeguard children and that staff working with children are trained, updated, supported and supervised appropriately in line with the statutory guidance *Working Together to Safeguard Children*.[3] This document, and its associated attachment, states that details of training should be determined locally, although it specifies the desired outcomes. Subsequent guidance from the four Royal Colleges, published by the Royal College of Paediatrics and Child Health,[4] states that any update/refresher training for safeguarding children at level 1 and at level 2 should be at regular intervals (a minimum of every three years) with written briefing of any changes in legislation and practice from named or designated professionals being made at least once a year.

We adopted this guidance as the basis for the follow-up review and applied it retrospectively to the original review to give a threshold of 0.33 staff trained each year*. Nevertheless, we recognise that this threshold is the minimum requirement to comply with the frequency of training during any one year and that best practice for trusts would be to provide more frequent, ideally annual, training in child protection for all staff (that is, closer to the 90% threshold that was used in the original review), as it is important to reinforce the need for staff to pay close attention to safeguarding children.

The indicators in this theme measure the number of nurses, consultant surgeons and consultant anaesthetists that have received the child protection training courses at level 1 or above in emergency care, day case care and surgical settings over a period of one year, as a proportion of all staff in each staff group respectively.

Figure 1 shows that 71% of trusts' scores across the indicators were categorised as either "improved" or "consistently high". However, it is a concern that there is still 29% of trusts' scores that have been found to be either "consistently low" (20%) or have "deteriorated" (9%) since the original review.

Although the number of trusts that have improved is encouraging, the overall results are still of concern, given that large numbers of trusts are failing to meet the minimum basic guidelines. There seems little justification for this, as many trusts already have 90% or more of their staff trained each year in child protection (see figure 2). Indeed, this suggests that the current recommended minimum for repeat training every three years should be increased to every year.

* The guidance implies that trusts should have a rolling programme of training and retraining so that all relevant staff will be trained and retrained every three years. For the purpose of this review, we have inferred that a third of all staff should be trained every year as a minimum.

Figure 1: Percentage of trusts' scores in each of the four categories for child protection

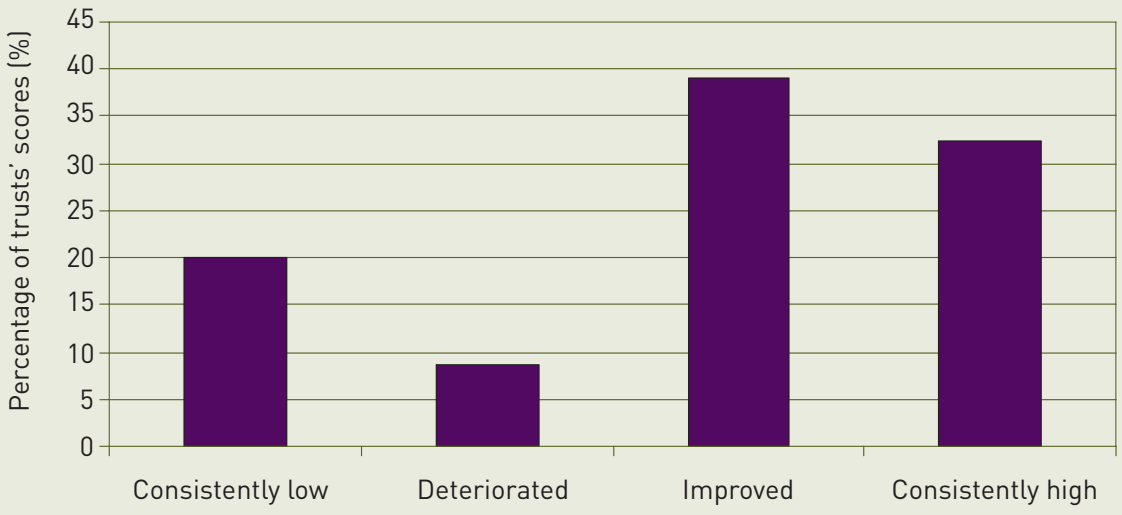
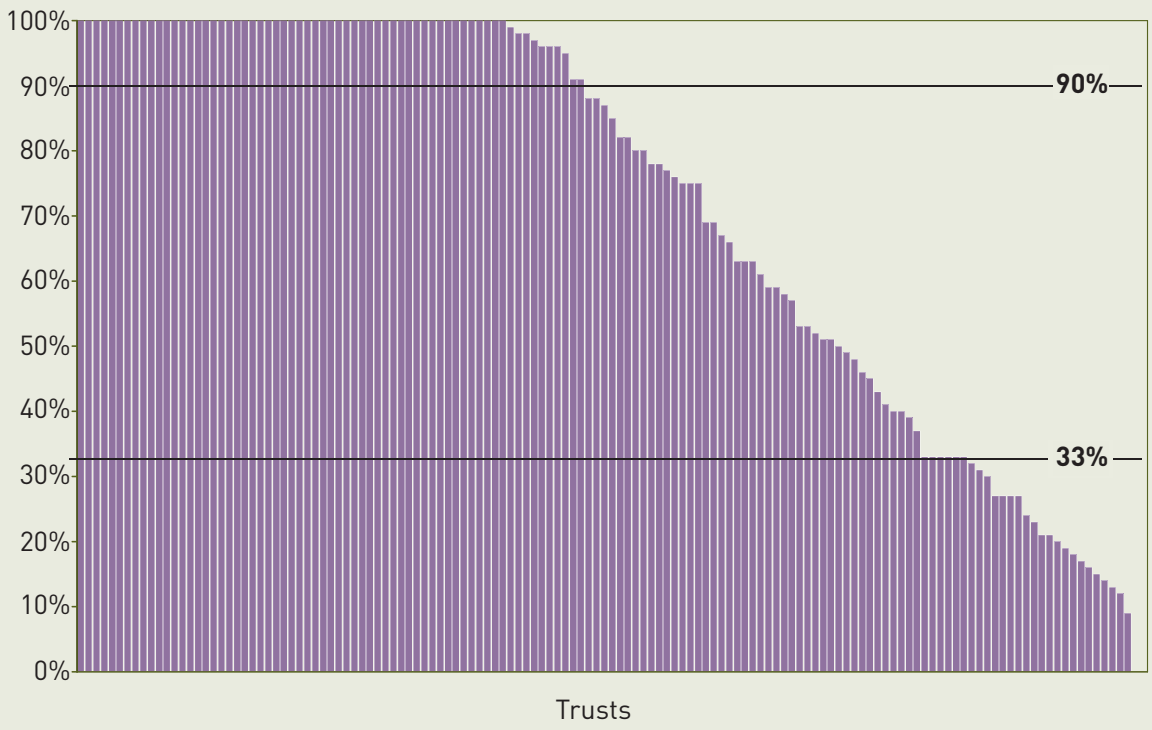


Figure 2: Number of registered nurses working in emergency care that have been trained in child protection level 1 as a proportion of all registered nurses working in emergency care



Theme 2: Managing pain

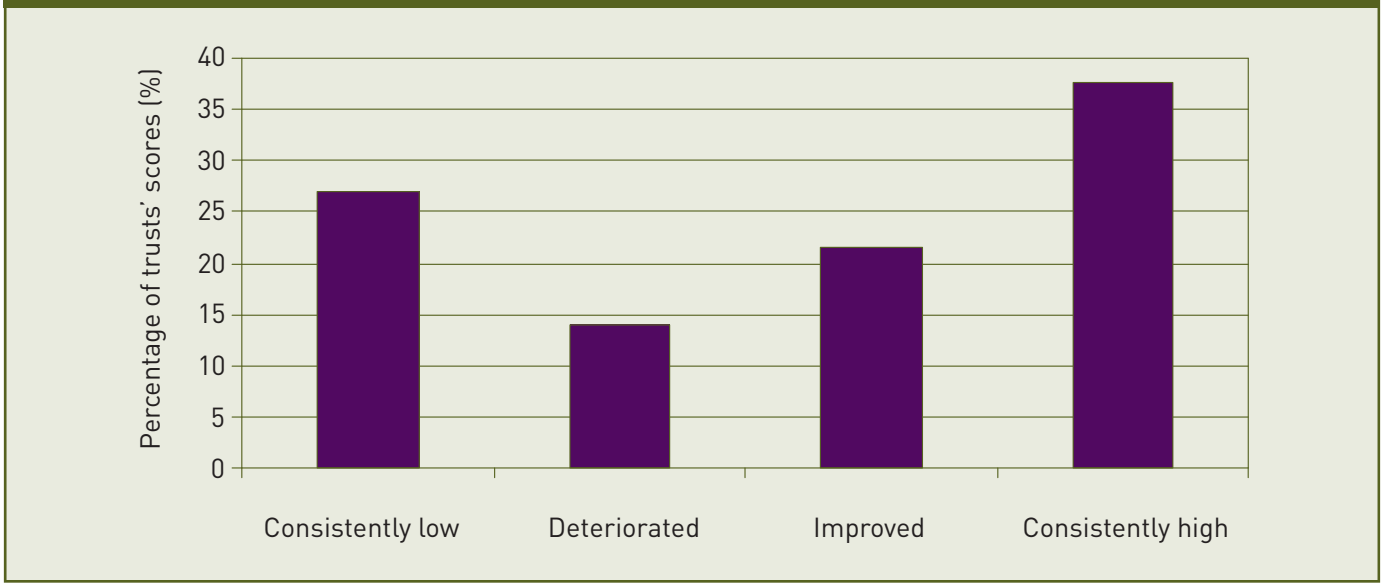
In our original review, we found that a large number of individual services did not have sufficient numbers of nurses trained to alleviate children's pain. Managing children's pain is particularly challenging, as many children are not as able as adults to communicate their pain. Training for staff is crucial for the effective management of pain in children.

In this theme, we focused on whether trusts have appropriate nursing staff trained to use paediatric pain assessment tools and administer analgesia according to Patient Group Directives (PGDs). This allows trained nurses to administer 'first line' pain relief according to agreed local protocols (without waiting for a medical authorisation) in the emergency care and day case care settings.

We found that 59% of trusts' scores were either "improved" or "consistently high" (see figure 3). "Improved" means that they have now met the threshold of at least 17% of nurses working in these care settings having received training (17% was calculated as equivalent to one nurse per shift). The "consistently high" category means that training levels have been maintained above this minimum threshold in both the original and the follow-up reviews.

However, less positively, the results show that 41% of trusts were either "consistently low performing" (27%), that is, they did not achieve the threshold in either the original or the follow-up review, or "deteriorated" (14%) meaning that their performance diminished since the original review. Trusts should check their individual reports and ensure that departments are staffed by suitably qualified personnel at all times when children may be seen.

Figure 3: Percentage of trusts' scores in each of the four categories for managing pain



Theme 3: Life support

In our original review, we found that, in a number of trusts, insufficient numbers of staff were trained to deliver resuscitation and initiate treatment in serious emergencies, and that the level of training in paediatric life support skills also varied considerably across trusts.

We followed up the performance of trusts in training their staff in:

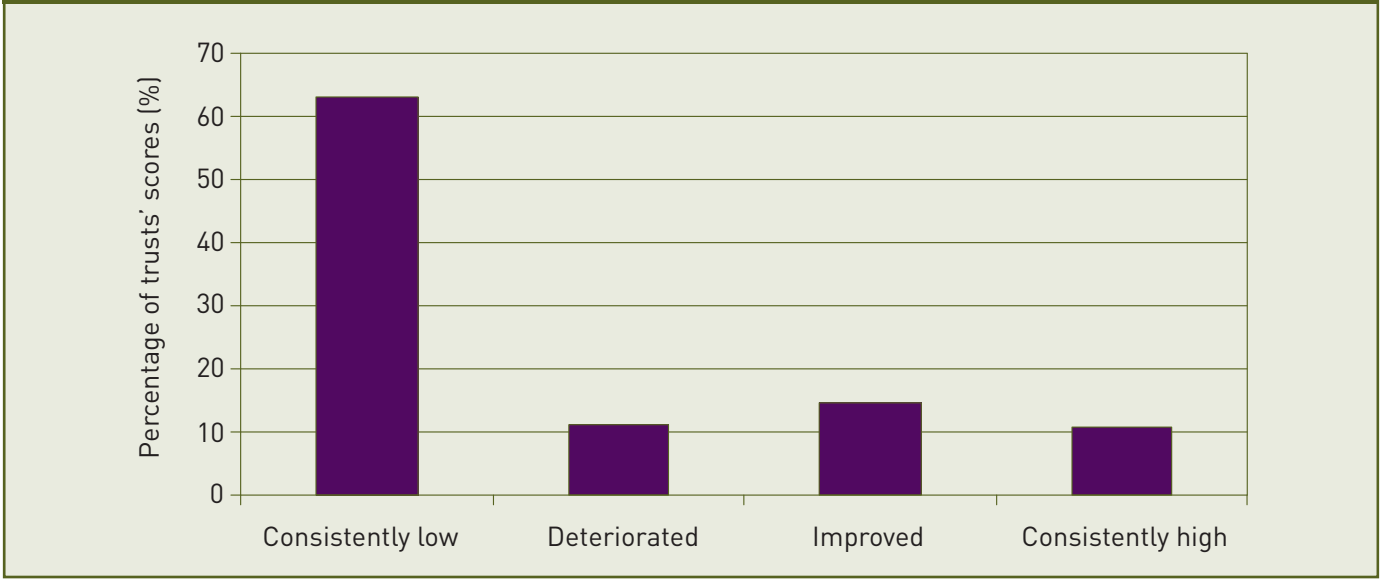
- Paediatric life support (PLS) or basic paediatric resuscitation training.
- Advanced paediatric life support (APLS), or equivalent courses such as European paediatric life support (EPLS) or paediatric advanced life support (PALS).

There are six indicators relating to different care settings in this theme that measure the proportions of nurses, consultant surgeons and consultant anaesthetists that had received life support training within the past year (see appendix B). Figure 4 shows the overall percentage of trusts' scores.

Only 26% of trusts' scores fell into the category of "improved" or "consistently high". The overwhelming majority of scores (63%) were categorised as "consistently low", meaning that they were below the threshold of training in both the original and follow-up review. Moreover, the follow-up review found that 11% of trusts were categorised as "deteriorated" since the original review. The results show that some trusts do not have adequately trained staff to cover all their services for children, or they fail to record the details of nursing and medical staff that have the appropriate and updated life support training.

It is important to highlight these results, so that trusts can focus on their responsibilities to ensure that staff who are working with children are up-to-date in their training and

Figure 4: Percentage of trusts' scores in each of the four categories for life support



competent in their resuscitation skills, as relevant to the settings in which they work and their level of contact with children. Courses other than APLS or its equivalent are now emerging locally, particularly for anaesthetists, and the boards of trusts should consider whether these may also be suitable.

We have already been liaising with the Child Health Mapping Team at Durham University that supplied the data for this follow-up review, and their questionnaire has now been changed to reflect the greater variety of courses available.

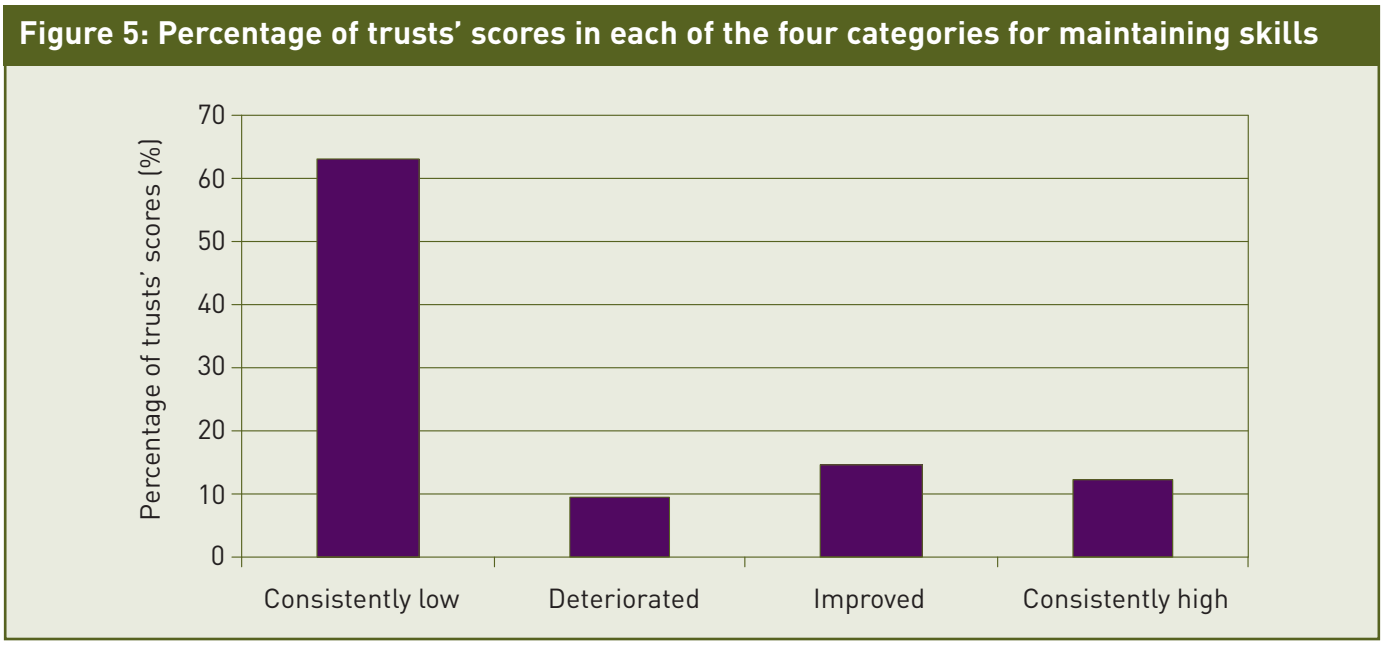
Theme 4: Maintaining the skills of staff in surgery and outpatient departments

Operative surgery in young children differs in many ways from that in adults, including access and management of the airway, handling of tissue, attention to fluid balance, and incision and wound closure. Young children cannot be treated surgically as if they were 'mini adults'. Some children's surgical disorders are rarely encountered in adults. Planned and emergency operative surgery and anaesthesia for young children needs to be carried out by staff who work with a sufficient number of children within any one year to maintain their skills. Similarly, in an outpatient setting, there should be at least one registered children's nurse present who is trained to recognise and meet the specific needs of children whenever children use the department.

Figure 5 shows the performance of trusts' scores for the theme. The thresholds differ according to the indicator in question, and are listed in appendix B.

We found that only 28% of trusts' scores across these indicators fell into the category of "improved" or "consistently high". This meant that 63% of the trusts were categorised as "consistently low", while 9% of trusts' scores were categorised as "deteriorated".

Figure 5: Percentage of trusts' scores in each of the four categories for maintaining skills



This theme describes two clearly defined services – 'surgery' and 'outpatient'. In surgery, 70% of the trusts' scores were categorised as either consistently low (60%) or as deteriorated (10%). It is a concern that so many trusts may offer younger children* surgical procedures carried out by surgeons (64%) and anaesthetists (74%) that have undertaken relatively few of the procedures in that age group. Regarding the staffing of outpatient departments, 78% of trusts fell into the category of either consistently low or deteriorated, meaning that many trusts do not have a registered children's nurse working in the outpatient department when it is open for children.

These poor results should be emphasised to trusts, so that they can focus on their responsibilities to ensure that staff maintain their skills and competencies in order to meet the good practice guidelines set by professional bodies. Furthermore, the results may raise questions relating to a trust's ability to continue to provide children and families with appropriate care locally. However, we do recognise that a balance has to be struck between providing care locally and the risk of not achieving sufficient numbers of procedures to allow staff to properly maintain their skills.

* Professional recommendations state that surgeons with an expertise in adults can undertake common and minor planned surgery on children over the age of eight. However, surgeons working with younger children need specific training and need to ensure that they work with a sufficient number of children to maintain their skills (see the report of the original review *Improving Services for Children in Hospital*).

Conclusions

This follow-up review has focused on the key areas for improvement that were identified in the original review of 2005/06, namely that many trusts were not systematically training staff or designing services to specifically meet the needs of children. The findings of the follow-up review indicate that, although the results of some trusts have improved, the overall progress made in addressing the weaknesses identified in the earlier review is disappointing. It demonstrates that many trusts still lack a robust approach to achieving a trained workforce that maintains its skills to continue to provide safe and good quality services for children. Indeed, the follow-up review has identified that there are still a number of trusts that do not have the appropriate records of training undertaken by staff in child protection courses or life support courses and do not give sufficient priority to submitting the data.

While there are some improvements in the important area of safeguarding children and managing pain, there are still trusts (29% and 41% of trusts' scores across the indicators within these themes respectively) that fail to meet the thresholds set. There appears to be a poor uptake of training in paediatric life support by nurses, consultant surgeons and consultant anaesthetists to meet guidelines set by the professional bodies, though in some trusts this may be a result of the poor recording of training undertaken. Recent publications such as *Why Children Die*[5] continue to highlight the need for effective training in A&E departments. The follow-up also shows evidence of a similar lack of improvement in ensuring that sufficient surgical activity is undertaken so that consultant surgeons and consultant anaesthetists can maintain their skills in carrying out surgical procedures for children.

Performance in the key themes of training in life support and maintaining skills in surgery and child focused care remain areas of concern and are in need of considerable improvement if the guidance recommended in our 2007 report is to be met by the majority of trusts. Many trusts are still unable to provide suitable staff coverage (a registered children's nurse) to meet the specific need of children in their outpatient department. Hospital trusts, PCT commissioning bodies and strategic health authorities need to work together to develop networks of services that are sustainable and at the same time meet local needs.

Recommendations

The key recommendations raised in the original review remain as important as ever.

Two years on from our original review, the results have demonstrated that there are still significant issues across the board and trusts must ensure that the delivery of services for children in hospital is seen as an immediate priority for focus and attention.

The delivery of high quality services for children in hospital requires a significant commitment by trusts to ensure a rolling programme of adequate training that updates all staff engaged with services for children. It also requires that surgeons and anaesthetists carry out sufficient work to maintain their skills. Trusts that need to improve should look to those trusts that are already achieving high levels of performance as beacons of good practice.

Effective governance and performance management of staff is the first step to

making certain that the training needs of staff are identified and addressed, so that the trust and its services can achieve the required thresholds and comply with the necessary guidelines. The maintenance of accurate and up-to-date records of training is an essential element of the management of this process.

It is essential that PCTs that commission services, strategic health authorities and Monitor work together with acute trusts to achieve and monitor a sustainable regional network of services for children that meet the good practice guidelines, supported by the correct level of training with adequately experienced staff. Trusts, as employers, must address their responsibilities to insist on the required professional training and experience identified for their staff to deliver effective and safe services for children in hospital and report their progress annually.

Trusts must ensure that:

- Staff that work with children are appropriately trained and are maintaining their skills in order to provide appropriate care and treatment for children.
- Staff that work with children in surgery and anaesthesia should be able to demonstrate that they have maintained the appropriate skills.
- Outpatient departments have the appropriate trained nurse attending while they are open for children.
- The management and monitoring of training has robust record-keeping procedures in place to ensure that the requirements of service standards are being met.
- Where there are constraints, they use the evidence from the follow-up review to consider whether they should continue to provide some services for children in the future.

Strategic health authorities and Monitor should ensure that, in collaboration with PCTs that commission services for children, the action plans that trusts develop following this review are monitored to ensure that they are being delivered, and that their outcomes are achieved within the declared timescale of the plans.

Local Safeguarding Children Boards should scrutinise the findings from their individual trusts and support the provision of appropriate training within and between professional groups.

The Department of Health, in cooperation with the appropriate professional bodies, should consider increasing the guideline minimum frequency for repeat training in child protection from once every three years to once a year. It should also consider whether some or all of these guidelines should be made minimum standards that are necessary for providing services for children.

Next steps

Each hospital trust that took part in the follow-up review has received an individual report detailing the outcomes for that particular trust. Based on these findings, those trusts that have been categorised as "consistently low performing" or "deteriorated" for the majority of the

indicators have been selected to work with our regional assessors on planning actions to improve. We invited the trusts with more than 55% of their indicators categorised as either "consistently low performing" or "deteriorated" to attend joint action planning workshops during January and February 2009. This amounted to more than 50% of participating trusts. To help trusts to plan the improvements for each of the relevant performance indicators, we produced a proforma action plan template specifically for use for this follow-up review, which provides a framework and clear guidance. Trusts' action plans will be submitted to their relevant strategic health authority or, in the case of foundation trusts, to Monitor.

All identified trusts are responsible for monitoring their action plans to ensure that the safety and quality of children's services is improved and sustained. They should do this in liaison with their strategic health authority or Monitor, and with their commissioning PCT and user groups as appropriate. The outcomes from the follow-up review and the subsequent action plans will feed into our overall screening database for trusts, enabling us to monitor progress in the future.

We encourage all trusts, whether or not they have been involved in the action planning workshops, to produce an action plan for each indicator that has been identified as "consistently low performing" or "deteriorated" for their trust, based on the template mentioned above.

Acknowledgement

We would like to thank the external members of our advisory group for their help with this follow-up review.

References

1. Healthcare Commission, *Improving Services for Children in Hospital*, February 2007

2. Department of Health, *National Service Framework for Children, Young People and Maternity Services*, October 2004

3. HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, 2006

4. Royal College of Paediatrics and Child Health, *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (intercollegiate document), April 2006

5. Confidential Enquiry into Maternal and Child Health (CEMACH), *Why Children Die: A pilot study*, May 2008

Appendix A: Selection of indicators for follow-up

A total of 143 scored indicators were generated from the original review, grouped by setting and category as outlined below:

- Children have access to child-specific services.
- Children have access to care local to their homes.
- Services are staffed by appropriate levels of trained staff.
- Staff have child-specific training.
- Staff have the opportunity to maintain their skills.

We provided trusts with a composite score for each setting and an overall score, which converted to a four-point rating ("weak" to "excellent") for the trust as a whole.

The rationale for selection

The selection of indicators for follow-up has been facilitated by a systematic process for distilling and prioritising the indicators from 143 to 11, which was agreed in consultation with a reference group. The rationale was as follows:

a) No indicators for inpatient services were selected because, in general, these inpatient services scored well.

b) Those indicators where a high proportion (over 45%) of trusts scored 1 (weak).

c) Training for nurses was selected as a proxy for child-focused accident and emergency (A&E) and day case facilities. While dedicated child-only settings were the preferred arrangement, some trusts simply did not have the facilities to segregate children's services, so it was determined and agreed that measurement of up-to-date child protection training was an appropriate indicator. We expected trusts to take measures to ensure that any staff who come into contact with children are appropriately trained (for example, staff in general A&E and general day care). By asking about the proportion of nurses that have the correct training, we will in fact be encouraging trusts to set up child-specific facilities as it is easier to train a small, focused group of nurses working within a children's A&E than it is to train the whole workforce in A&E, for example.

d) The small number of follow-on indicators focused only on 'essential' and 'necessary' training, omitting the questions about 'desirable' training. The desirable nursing courses are important, however, in terms of priorities, it was agreed that 'desirable' training was not as important as the essential/necessary courses such as paediatric life support (PLS) and child protection training.

e) Outcomes from the original review identified particular and significant concerns pertaining to all elements of training for surgeons and anaesthetists. An indicator to encourage and measure ownership across the hospital, in surgical directorates, would be a key improvement resulting from our review. However, collecting this data is burdensome, as it encompasses four professions. Therefore, for the purpose of the follow-up we focused on essential training courses for consultant surgeons and anaesthetists only.

Appendix B: List of follow-up themes, indicators and thresholds

Key themes used to discuss the national findings	
Four themes:	**Indicators:**
Child protection	EC1a, DC1a, S1a & S2a
Managing pain	EC2 b, EC2c, DC2b & DC2c
Life support	EC1c, EC2a, DC1c, DC2a, S1b & S2b
Maintaining skills	OP1, S3 & S5
The two indicators (EC1b and DC1b) are not included in the child protection theme to avoid any double counting. These two indicators asked whether staff have received child protection training at level 2 or higher; whereas the two indicators (EC1a and DE1a) included in the safeguarding children theme already asked whether staff have received child protection training at level 1 or higher.	

Description of the follow-up indicators and components of the six composite indicators				
Indicators used in the original review	**Indicators**	**Indicators used in the follow-up review**	**Threshold**	
			Low performing	**High performing**
1. EC1 Proportion of registered nurses (RNs and RN-Cs) who work in emergency care settings that have undertaken 'essential training' courses over a period of one year. 'Essential training' courses: 1. Child protection level 1 or above, 2. Child protection level 2 or above, 3. Basic paediatric life support or PLS	**1. EC1a**	Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the child protection training at level 1 or higher within the last year.	**<0.33**	**>=0.33**
	2. EC1b	Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the child protection training at level 2 or higher within the last year.	**<0.33**	**>=0.33**
	3. EC1c	Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the basic paediatric life support or PLS training within the last year.	**<0.9**	**>=0.9**

Description of the follow-up indicators and components of the six composite indicators				
Indicators used in the original review	**Indicators**	**Indicators used in the follow-up review**	**Threshold**	
			Low performing	**High performing**
2. DC1 Proportion of registered nurses (RNs and RN-Cs) who work in day care settings that have undertaken 'essential training' courses over a period of one year. 'Essential training' course: 1. Child protection level 1 or above, 2. Child protection level 2 or above, 3. Basic paediatric life support or PLS	**4. DC1a**	Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the child protection training at level 1 or higher within the last year.	**<0.33**	**>=0.33**
	5. DC1b	Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the child protection training at level 2 or higher within the last year.	**<0.33**	**>=0.33**
	6. DC1c	Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the basic paediatric life support or PLS training within the last year.	**<0.9**	**>=0.9**

Description of the follow-up indicators and components of the six composite indicators				
Indicators used in the original review	**Indicators**	**Indicators used in the follow-up review**	**Threshold**	
			Low performing	**High performing**
3. EC2 Proportion of registered nurses (RNs and RN-Cs) who work in emergency care settings that have undertaken the 'necessary training' courses (1 trained nurse per shift is needed; this indicator assumes a shift pattern of 1 in 6). 'Necessary training': 1. APLS or equivalent, 2. Pain assessment, 3. Administration of analgesia.	**7. EC2a**	Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the advanced paediatric life support/EPLS/PALS training within the last 3 years.	**<0.17**	**>=0.17**
	8. EC2b	Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the formal training for the use of paediatric pain assessment tools.	**<0.17**	**>=0.17**
	9. EC2c	Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the administration of analgesia via PGDs training.	**<0.17**	**>=0.17**

Description of the follow-up indicators and components of the six composite indicators				
Indicators used in the original review	**Indicators**	**Indicators used in the follow-up review**	**Threshold**	
			Low performing	**High performing**
4. DC2 Proportion of registered nurses (RNs and RN-Cs) that have the necessary training for outpatient care settings (1 trained nurse per shift is needed; this indicator assumes a shift pattern of 1 in 6). Registered nurses undertaken: 1. APLS or equivalent, 2. Pain assessment, 3. Administration of analgesia.	**10. DC2a**	Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the APLS/EPLS/PALS training within the last 3 years.	**<0.17**	**>=0.17**
	11. DC2b	Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the formal training for the use of paediatric pain assessment tools.	**<0.17**	**>=0.17**
	12. DC2c	Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the administration of analgesia via PGDs training.	**<0.17**	**>=0.17**
5. OP1 Is there at least one RN-C (registered children's nurse) working within each outpatient department in the trust, whenever the department is being used by children?	**13. OP1**	Is there at least one RN-C (registered children's nurse) working within each outpatient department in the trust, whenever the department is being used by children?	**0=no**	**1=yes**

Description of the follow-up indicators and components of the six composite indicators				
Indicators used in the original review	**Indicators**	**Indicators used in the follow-up review**	**Threshold**	
			Low performing	**High performing**
6. S1 Number of surgeon consultants (general, orthopaedic & ENT) trained in essential training courses / headcount surgeons undertaken: 1. Child protection level 1 or above, 2. PLS or equivalent.	**14. S1a**	Proportion of consultant surgeons (general, orthopaedic & ENT) in the trust that have received the child protection training at level 1 or higher within the last year.	**<0.33**	**>=0.33**
	15. S1b	Proportion of consultant surgeons (general, orthopaedic & ENT) in the trust that have received the paediatric life support or equivalent training within the last year.	**<0.9**	**>=0.9**
7. S2 Number anaesthetist consultants trained in essential training courses/headcount anaesthetists consultants undertaken: 1. Child protection level 1 or above, 2. APLS or equivalent.	**16. S2a**	Proportion of consultant anaesthetists (elective and emergency) in the trust that have received the child protection training at level 1 or higher within the last year.	**<0.33**	**>=0.33**
	17. S2b	Proportion of consultant anaesthetists (elective and emergency) in the trust that have received the advanced paediatric life support /EPLS/PALS/or equivalent training within the last 3 years.	**<0.9**	**>=0.9**

Description of the follow-up indicators and components of the six composite indicators				
Indicators used in the original review	**Indicators**	**Indicators used in the follow-up review**	**Threshold**	
			Low performing	**High performing**
8. S3 Number of consultant anaesthetists carrying out very low levels of work (1-20 anaesthetics) as % all consultant anaesthetists carrying out work on children in the trust.	**18. S3**	Proportion of consultant anaesthetists (elective and emergency) in the trust that carried out fewer than 21 anaesthetics in the year on children aged 29 days -12 years in the year.	**>0**	**0**
9. S5 Number of consultant surgeons' teams carrying out insufficient levels of work (0-100 FCEs) as % all surgeon teams carrying out work on children - those who do elective work.	**19. S5**	Proportion of consultant surgeons' teams (elective and emergency) in the trust that carried out low levels of work (1-99 finished consultant episodes) on children in the year.	**>average (0.82)**	**<=0.82**

Appendix C: Summary of the results for the 19 indicators

Indicator EC1a: Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the child protection training at level 1 or higher within the last year.	
Performance category	**Indicators**
Consistently high performing	49
Improved	25
Deteriorated	10
Consistently low performing	11
Non applicable/no category	5

Indicator EC1b: Proportion of registered nurses (RNs and RN-Cs) in emergency care settings that have received the child protection training at level 2 or higher within the last year.	
Performance category	**Indicators**
Consistently high performing	24
Improved	20
Deteriorated	19
Consistently low performing	33
Non applicable/no category	4

Indicator EC1c: Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the basic paediatric life support or PLS training within the last year.	
Performance category	**Indicators**
Consistently high performing	7
Improved	15
Deteriorated	14
Consistently low performing	60
Non applicable/no category	4

Indicator DC1a: Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the child protection training at level 1 or higher within the last year.	
Performance category	**Indicators**
Consistently high performing	48
Improved	31
Deteriorated	8
Consistently low performing	12
Non applicable/no category	1

Indicator DC1b: Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the child protection training at level 2 or higher within the last year.	
Performance category	**Indicators**
Consistently high performing	24
Improved	23
Deteriorated	21
Consistently low performing	29
Non applicable/no category	3

Indicator DC1c: Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the basic paediatric life support or PLS training within the last year.	
Performance category	**Indicators**
Consistently high performing	22
Improved	22
Deteriorated	16
Consistently low performing	38
Non applicable/no category	1

Indicator EC2a: Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the advanced paediatric life support/EPLS/PALS training within the last three years.	
Performance category	**Indicators**
Consistently high performing	24
Improved	14
Deteriorated	18
Consistently low performing	33
Non applicable/no category	10

Indicator EC2b: Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the formal training for the use of paediatric pain assessment tools.	
Performance category	**Indicators**
Consistently high performing	44
Improved	21
Deteriorated	9
Consistently low performing	16
Non applicable/no category	10

Indicator EC2c: Proportion of registered nurses (RNs and RN-Cs) in the emergency care settings that have received the administration of analgesia via PGDs training.	
Performance category	**Indicators**
Consistently high performing	49
Improved	19
Deteriorated	13
Consistently low performing	8
Non applicable/no category	11

Indicator DC2a: Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the APLS/EPLS/PALS training within the last three years.	
Performance category	**Indicators**
Consistently high performing	9
Improved	20
Deteriorated	13
Consistently low performing	54
Non applicable/no category	4

Indicator DC2b: Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the formal training for the use of paediatric pain assessment tools.	
Performance category	**Indicators**
Consistently high performing	32
Improved	21
Deteriorated	16
Consistently low performing	28
Non applicable/no category	3

Indicator DC2c: Proportion of registered nurses (RNs and RN-Cs) in the day case care settings that have received the administration of analgesia via PGDs training.	
Performance category	**Indicators**
Consistently high performing	14
Improved	18
Deteriorated	14
Consistently low performing	49
Non applicable/no category	4

Indicator OP1: Is there at least one RN-C (registered children's nurse) working within each outpatient department in the trust, whenever the department is being used by children?	
Performance category	**Indicators**
Consistently high performing	6
Improved	16
Deteriorated	8
Consistently low performing	70
Non applicable/no category	0

Indicator S1a: Proportion of consultant surgeons (general, orthopaedic & ENT) in the trust that have received the child protection training at level 1 or higher within the last year.	
Performance category	**Indicators**
Consistently high performing	12
Improved	44
Deteriorated	9
Consistently low performing	33
Non applicable/no category	2

Indicator S1b: Proportion of consultant surgeons (general, orthopaedic & ENT) in the trust that have received the paediatric life support or equivalent training within the last year.	
Performance category	**Indicators**
Consistently high performing	0
Improved	4
Deteriorated	0
Consistently low performing	94
Non applicable/no category	2

Indicator S2a: Proportion of consultant anaesthetists (elective and emergency) in the trust that have received the child protection training at level 1 or higher within the last year.	
Performance category	**Indicators**
Consistently high performing	17
Improved	54
Deteriorated	6
Consistently low performing	21
Non applicable/no category	2

Indicator S2b: Proportion of consultant anaesthetists (elective and emergency) in the trust that have received the advanced paediatric life support /EPLS/PALS/or equivalent training within the last three years.	
Performance category	**Indicators**
Consistently high performing	1
Improved	8
Deteriorated	3
Consistently low performing	84
Non applicable/no category	3

Indicator S3: Proportion of consultant anaesthetists (elective and emergency) in the trust that carried out fewer than 21 anaesthetics in the year on children aged 29 days -12 years in the year.	
Performance category	**Indicators**
Consistently high performing	6
Improved	19
Deteriorated	6
Consistently low performing	68
Non applicable/no category	1

Indicator S5: Proportion of consultant surgeons' teams (elective and emergency) in the trust that carried out low levels of work (1-99 finished consultant episodes) on children in the year.	
Performance category	**Indicators**
Consistently high performing	27
Improved	8
Deteriorated	13
Consistently low performing	51
Non applicable/no category	1

Appendix D: Recommendations from professional publications subsequent to the 2007 report on services for children in hospital

1. Association of Paediatric Anaesthetists, Royal College of Paediatrics and Child Health, Royal College of Anaesthetists, *Child protection and the anaesthetist: Safeguarding children in the Operating Theatre*, 2006 http://www.rcpch.ac.uk/Policy/Child-Protection/Child-Protection-Publications

2. Royal College of Surgeons of England, *Surgery for Children: Delivering a First Class Service* (Report of the Children's Surgical Forum), July 2007 http://www.rcseng.ac.uk/publications/docs/CSF.html

3. Royal College of Paediatrics and Child Health, *Safeguarding Children and Young People: Roles and Competences for Health Care Staff* (Intercollegiate Document), April 2006 http://www.rcpch.ac.uk/Policy/Child-Protection/Child-Protection-Publications

4. Royal College of Paediatrics and Child Health, *Services for Children in Emergency Departments* (Report of the Intercollegiate Committee for Services for Children in Emergency Departments), April 2007 http://www.rcpch.ac.uk/Policy/Emergency-Care

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Healthcare Commission

Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Maid Marian House
56 Hounds Gate
Nottingham
NG1 6BE

Dominions House
Lime Kiln Close
Stoke Gifford
Bristol
BS34 8SR

Kernel House
Killingbeck Drive
Killingbeck
Leeds
LS14 6UF

5th Floor
Peter House
Oxford Street
Manchester
M1 5AX

1st Floor
1 Friarsgate
1011 Stratford Road
Solihull
B90 4AG

Telephone 020 7448 9200
Facsimile 020 7448 9222
Helpline 0845 601 3012

Email feedback@healthcarecommission.org.uk
Website www.healthcarecommission.org.uk

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